Wishes Care and Support Yorkshire Ltd

Wishes Care and Support Yorkshire

Inspection report

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12 July 2021
19 July 2021

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Wishes Care and Support Services is a domiciliary care agency providing care and support to people in their own home. At the time of inspection, the provider delivered services to 180 people. Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider failed to submit statutory notifications to CQC for all reportable incidents in line with their regulatory responsibilities.

We found inconsistencies in both the provider's and staff members approach to managing accidents and incidents and risks to people using the service. The provider had failed to implement outcomes of investigations relating to safeguarding concerns, including accidents and incidents.

There was no oversight by the provider or registered manager in relation to the quality and safety of the service. Therefore, opportunities to learn lessons and drive improvements had been missed.

Staff were recruited safely and attended a full programme of induction.

People told us their care staff were kind and considerate, they told us they felt safe.

Staff told us the management team were open and transparent and supported them with any issues or concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 7 October 2017).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety and the management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led

sections of this full report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Wishes Care and Support Yorkshire

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 9 July 2021 and ended on 30 July 2021. We visited the office location on 12 July 2021 and 19 July 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the provider, registered manager, quality and compliance manager, care coordinator, trainer and a senior carer.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three people who used the service and their relatives and two care staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider did not appropriately assess risks to people using the service or take action to mitigate risks. There was no evidence to demonstrate how the provider or registered manager monitored the safety of the service. Lessons learned were not always considered or shared with the wider staff team.
- The provider did not complete any analysis of accidents and incidents to identify areas of concern and use this information improve the safety of the service.
- The provider had not altered risk assessments in a timely manner following incidents, placing people at increased risk of harm.
- Medical attention was not always sought in a timely manner following falls, placing people at increased risk of harm.

The provider had failed to ensure risks were appropriately assessed or managed to keep people safe. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to safeguard people from the risk of abuse were ineffective.
- Staff's approach to managing safeguarding concerns was inconsistent. Investigations following reports of accidents and incidents were not always completed fully. Outcomes were not always concluded.
- Shortfalls and concerns in relation to the management and recording of accidents and incidents had not been identified by the providers governance systems.

We recommend the provider reviews the current systems and processes in place and make the necessary improvements to ensure a consistent approach to safeguarding.

- Staff received training in safeguarding and how to identify and report types of abuse.
- People told us they felt safe and supported by care staff. People told us "I know who the manager is, the manager has done my call when my carer was off." and "I like to have the same few carers who know me well."

Staffing and recruitment

- People told us that their care visits were often late and felt this was down to a lack of staff. Relatives told us they had been asked to step in to provide care when staffing numbers were low. We discussed this with

the provider who explained that whilst they employed sufficient numbers of staff for the number of people requiring support, events beyond their control had impacted on care delivery on occasions. One relative told us "I've had to cover (relative name) calls for the last few weekends because they have no staff."

We recommend the provider reviews their contingency plans in the event of staff shortages to ensure appropriate numbers of trained staff are available to meet people's needs.

● Staff were recruited safely and attended a programme of induction and shadowing experienced staff before working independently.

Using medicines safely
● The provider completed audits of medication record charts and staff were supported and retrained when medicine errors had occurred in order to enhance and support learning.
● People's care plans contained information about their prescribed medicines and the type of assistance required to receive their prescribed medicines.
● Staff received training in the safe administration of medicines and their competency was checked regularly by senior care staff.

Preventing and controlling infection
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for staff.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had failed to notify the CQC of multiple reportable incidents including allegations of abuse.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

- People were at risk of harm because the provider did not have effective systems in place to demonstrate oversight of the service provided to people.
- There was limited evidence of learning lessons following accidents and incidents as the approach was inconsistent. This included the failure to complete management reviews as stipulated in the providers accident and incident reporting policy.

The failure to establish effective systems to assess, monitor and improve the quality and safety of the service and mitigate risks was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; Continuous learning and improving care

- The provider were unable to produce records to confirm staff had received appropriate training in the safe care and support for people with a percutaneous endoscopic gastrostomy (PEG).
- Effective systems were not in place to ensure continuous learning and improving care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider regularly engaged with people who use the service to check if they were satisfied with the service provided.
- Staff attended regular meetings to discuss service updates and changes. Staff were encouraged to give feedback around any issues or concerns.
- People and staff gave positive feedback about the management team.
- The provider understood their responsibility to be open and honest when things went wrong.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks were appropriately assessed or managed to keep people safe. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established and operated effective systems to assess, monitor and improve the quality and safety of the service and to mitigate risks. Regulation 17(1)(2)(a)(b)(f).